

1 MAUREEN E. MCCLAIN (State Bar No. 062050)
2 Email: mcclain@kmm.com
3 ALEX HERNAEZ (State Bar No. 201441)
4 Email: hernaez@kmm.com
5 KAUFF MCCLAIN & MCGUIRE LLP
One Post Street, Suite 2600
San Francisco, California 94104
Telephone: (415) 421-3111
Facsimile: (415) 421-0938

6 Attorneys for Defendant
7 ALTA BATES SUMMIT MEDICAL CENTER

8 TAZAMISHA H. IMARA (State Bar No. 201266)
Email: imara@kmm.com
9 KAUFF MCCLAIN & MCGUIRE LLP
2049 Century Park East
Suite 2690
10 Los Angeles, CA 90067
Telephone: (310) 277-7550
11 Facsimile: (310) 277-7525

12 Attorneys for Defendant
13 ALTA BATES SUMMIT MEDICAL CENTER

14 UNITED STATES DISTRICT COURT
15 NORTHERN DISTRICT OF CALIFORNIA

16
17 COYNES L. ENNIX, JR., M.D.,

CASE NO. C 07-2486 WHA

18 Plaintiff,

DEFENDANT'S MOTION IN LIMINE
NO. 4 TO EXCLUDE EVIDENCE
RELATING TO MORTALITY
STATISTICS

19 v.

20 ALTA BATES SUMMIT MEDICAL CENTER,

DATE: May 19, 2008
TIME: 2:00 p.m.
DEPT: Ctrm. 9, 19th Floor
JUDGE: Hon. William H. Alsup

21 Defendant.

22
23 COMPLAINT FILED: May 9, 2007
TRIAL DATE: June 2, 2008

24

25

26

27

28

1 **I. INTRODUCTION**

2 Defendant Alta Bates Summit Medical Center ("ABSMC" or "the Hospital"),
 3 hereby applies for an order *in limine*, directing that Plaintiff Coyness L. Ennix ("Plaintiff"),
 4 his counsel, and witnesses be precluded from presenting evidence or argument in the
 5 presence of the jury concerning mortality statistics collected by the California Office of
 6 Statewide Health Planning and Development's Coronary Artery Bypass Graft Surgery
 7 Reporting Program (the "CCORP Statistics"). The statistics do not include any
 8 information about the mortality rate incident to valve procedures performed by Plaintiff.
 9 These procedures were a significant basis for the peer review of Plaintiff's surgical
 10 practices. The CCORP Statistics are not relevant to the issues to be tried in this action.
 11 Even if they were found to be relevant, they are substantially more prejudicial than
 12 probative – and therefore inadmissible.

13 **II. FACTUAL AND PROCEDURAL BACKGROUND**

14 Following an extensive peer review of Plaintiff's surgical practices and
 15 outcomes, the Summit Medical Staff Medical Executive Committee's ("MEC") restricted
 16 Plaintiff to surgical assisting between May and October 2005, and to proctoring between
 17 October and July of 2005. This action concerns Plaintiff's claims that the Hospital's
 18 decision to refer him for peer review, and MEC's resultant disciplinary actions constituted
 19 race discrimination and were in violation of 42 U.S.C. § 1981.

20 Among the factors examined as part of the peer review process was the
 21 mortality rate of Plaintiff's patients. (Decl. of Lamont D. Paxton in Supp. Of ABSMC's
 22 Motion to Strike ("Paxton Decl.") ¶ 4.) The mortality statistics utilized in the peer review
 23 process compared Plaintiff's mortality rates with those of his partners, as well as with
 24 other cardiac surgeons nationwide. (Paxton Decl. ¶ 7.) The Hospital anticipates that
 25 Plaintiff will seek to introduce a different set of statistics in an effort to demonstrate that
 26 Plaintiff's mortality rate was within acceptable limits, and that another physician at the
 27 hospital had a higher mortality rate. It is expected that the CCORP Statistics will be
 28

1 introduced in an effort to show that the proffered reasons for the referral peer review and
 2 the resulting discipline were false, and therefore pretextual.

3 The statistics Plaintiff intends to rely upon are collected by the California
 4 Office of Statewide Health Planning and Development's Coronary Artery Bypass Graft
 5 Surgery Reporting Program. (Plaintiff's MPA in Opposition to ABSMC's MSJ (Opp.
 6 MSJ"), 12:19-13:21.) Based on these statistics, Plaintiff asserts that his "risk-adjusted
 7 mortality rate during 2003 and 2004 at ABSMC was 4.79, well within the acceptable
 8 range statewide...[and his] peers had similar mortality rates, but . . . at least one
 9 Caucasian peer had a risk-adjusted mortality rate at ABSMC of 6.45, over 34 percent
 10 higher than Dr. Ennix." (Opp. MSJ 13:1-5.)

11 The CCORP Statistics list mortality rates for coronary bypass procedures
 12 only, and cover only the years 2003 and 2004. (Decl. of Andrew Sweet in Opp. to
 13 ABSMC's MSJ ("Sweet Decl."), Ex. Z, p. 12.) By contrast, the statistics utilized in the
 14 peer review process that resulted in the restriction of Plaintiff's surgical privileges
 15 documented statewide mortality rates associated with *both* valve and coronary bypass
 16 procedures. (Paxton Decl., ¶3, Ex. A p. 21.¹) Plaintiff performed both types of surgeries.
 17 In addition, the mortality statistics utilized as part of the peer review of Plaintiff's surgical
 18 practices covered the years 1999 through April 30, 2005. (Paxton Decl. ¶ 8, Ex. B.)²
 19 Plaintiff seeks to introduce the truncated CCORP data that excludes two-thirds of the
 20 time period covered by the peer review, and all of the valve procedures performed by
 21 Plaintiff.

22

23

24

25 ¹ For the Court's convenience, the statistics in question, which compare Plaintiff's
 26 mortality rate to that of his appears are attached as Exhibit A to this motion. This data
 27 was submitted in support of Defendant's motion for summary judgment as Exhibit B to
 28 the Declaration of Lamont D. Paxton.

25 ² These statistics demonstrate that the mortality rate associated with valve and coronary
 26 bypass procedures performed by Plaintiff was 7.4% during the 6.5 years reviewed, as
 27 compared to his partners' overall 3.8% mortality rate. (Paxton Decl., Ex. A. p. 70.)

1 **III. ARGUMENT**

2 **A. The CCORP Statistics Relied Upon by Plaintiff Are Irrelevant.**

3 The Federal Rules of Evidence provide that only relevant evidence is
 4 admissible at trial. Relevant evidence is defined as:

5 evidence having any tendency to make the existence
 6 of any fact that is of consequence to the
 7 determination of the action more probable or less
 8 probable than it would be without the evidence.

9 F.R.E. 401; *Daubert v. Merrell Dow Pharmaceuticals, Inc.* (1993) 509 U.S. 579, 587.

10 The CCORP statistics fail to meet this basic test of admissibility. It is anticipated that the
 11 statistics will be offered as evidence that Plaintiff's mortality rates were on par with those
 12 of his peers, not a legitimate object of concern for the Hospital, and indicative of pretext.

13 The CCORP data addresses only surgical outcomes attendant to coronary
 14 bypass procedures. By contrast, the peer review of Plaintiff concerned practices and
 15 outcomes incident to both coronary bypass and valve procedures. (Paxton Decl. ¶ 3,
 16 Ex. A, p. 21.) Indeed, the most negative outcomes examined in the course of the peer
 17 review concerned breaches of the standard of care occurring in connection with valve
 18 procedures—including, lengthy surgical times, excessive use of blood products and
 19 negative patient outcomes, including death. That Plaintiff's mortality statistics are more
 20 favorable relative to those of his colleagues if the valve procedures he performed are
 21 excluded from the analysis is not probative of any matter at issue in this case.

22 Moreover, the CCORP statistics Plaintiff intends to rely upon were
 23 compiled only after Plaintiff's peer review. Thus, the data which Plaintiff claims
 24 undermines the outcome of the peer review process and the subsequent discipline was
 25 not even available at the time of the peer review. Plaintiff should not be permitted to
 26 second-guess the peer review outcome based on after-the-fact statistics.

1 **B. The CCORP Statistics Are Substantially More Prejudicial Than**
 2 **Probative and Therefore Inadmissible.**

3 Even assuming, *arguendo*, that the statistical data in question is relevant, it
 4 remains inadmissible. “[R]elevance is not always enough. Even though evidence is
 5 relevant, the probative value as well as the harmful consequences that might flow from
 6 its admission must be assessed.” *Coursesen v. A. H. Robins Co., Inc.* (9th Cir, 1985) 764
 7 F.2d 1329, 1340, *citing Cohn v. Papke* (9th Cir, 1981) 655 F.2d 191, 194. The statistics
 8 Plaintiff seeks to rely upon are significantly more prejudicial than probative, and are
 9 inadmissible on that basis pursuant to F.R.E. 403. Rule 403 provides:

10 Although relevant, evidence may be excluded if its
 11 probative value is substantially outweighed by the
 12 danger of unfair prejudice, confusion of the issues, or
 13 misleading the jury, or by considerations of undue
 14 delay, waste of time, or needless presentation of
 15 cumulative evidence.

16 F.R.E. 403. District courts are accorded great latitude in determining
 17 whether the prejudicial effect of evidence outweighs its probative value. *Trevino v.*
 18 *Gates* (9th Cir. 1996) 99 F.3d 911, 922. Plaintiff seeks to rely upon the CCORP data
 19 precisely because it does not take into account outcomes associated with valve
 20 procedures. The CCORP statistics also cover a significantly shorter time period than
 21 those which were reviewed as part of the peer review process. As a result of this
 22 significantly narrowed scope, the CCORP statistics attribute a somewhat lower mortality
 23 rate to Plaintiff's surgeries. The CCORP Statistics pose an unreasonable risk of
 24 confusing and misleading the jury with regard to the actual rate of mortality associated
 25 with the entirety of Plaintiff's surgical work.

26 ///

27 ///

28 ///

IV. CONCUSSION

For each of the foregoing reasons, Defendant Alta Bates Summit Medical Center respectfully requests an order in limine preventing Plaintiff from introducing testimony or evidence related or referring to the CCORP mortality statistics at trial.

DATED: April 29, 2008

Respectfully submitted,

KAUFF MCCLAIN & MCGUIRE LLP

By: 

Atorneys for Defendant
ALTA BATES SUMMIT MEDICAL
CENTER

4845-7846-1186.2

EXHIBIT A

CONFIDENTIAL

APPENDIX B

Tabular STS Data as Provided to the Ad Hoc Committee by Dr. Ennix

	1999	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE	24	2			8.3%	1.03%	27.0%
ACB only	17	2		2.7%	11.8%	1.46%	36.4%
Isolated Valve	2	0		9.6%	0.0%	0.00%	77.6%
ACB + Valve	0	0		n/a	0.0%	n/a	n/a
Non CE and Non-Kaiser MDs	267	12			4.5%	2.34%	7.7%
ACB only Other MDs	180	8		4.0%	4.4%	1.94%	8.6%
Isolated Valve Other MDs	38	0		3.7%	0.0%	0.00%	7.6%
ACB + Valve Other MDs	17	1		8.1%	9.0%	0.15%	28.7%
Summit total	291	14			4.8%	2.66%	7.9%
	2000						
	2000	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE	56	4			7.1%	1.98%	17.3%
ACB only	47	1		3.1%	2.1%	0.05%	11.3%
Isolated Valve	4	0		2.2%	0.0%	0.00%	57.2%
ACB + Valve	1	1		29.7%	100.0%	5.00%	100.0%
Non CE	297	8			2.7%	1.17%	5.2%
ACB only Other MDs	217	6		3.7%	2.8%	1.02%	5.9%
Isolated Valve Other MDs	26	1		4.7%	3.0%	0.10%	19.6%
ACB + Valve Other MDs	17	0		8.4%	0.0%	0.00%	16.2%
Summit total	353	12			3.4%	1.77%	5.9%
	2001						
	2001	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE	51	3			5.9%	1.23%	16.2%
ACB only	39	2		2.8%	5.1%	0.63%	17.3%
Isolated Valve	6	1		4.9%	16.7%	0.42%	64.1%
ACB + Valve	3	0		3.5%	0.0%	0.00%	63.2%
Non CE	238	11			4.6%	2.33%	8.2%
ACB only Other MDs	152	6		4.0%	3.9%	1.46%	8.4%
Isolated Valve Other MDs	39	0		7.3%	0.0%	0.00%	7.4%
ACB + Valve Other MDs	18	2		7.9%	10.5%	1.30%	33.1%
Summit total	289	14			4.8%	2.67%	8.0%
	2002						
	2002	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE	64	3			4.7%	0.98%	13.1%
ACB only	46	2		2.4%	4.3%	0.53%	14.6%
Isolated Valve	6	0		3.6%	0.0%	0.00%	39.3%
ACB + Valve	1	1		15.5%	100.0%	5.00%	100.0%
Non CE and Non-Kaiser MDs	246	4			1.6%	0.44%	4.1%
ACB only Other MDs	163	3		3.0%	1.8%	0.38%	5.3%
Isolated Valve Other MDs	30	0		6.2%	0.0%	0.00%	9.5%
ACB + Valve Other MDs	18	0		7.9%	0.0%	0.00%	15.3%
Summit total	310	7			2.3%	0.91%	4.6%

CONFIDENTIAL

Page 1

E000658

	2003	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE		118	10		8.5%	4.14%	15.0%
ACB only		73	1	3.8%	1.4%	0.03%	7.4%
Isolated Valve		10	2	2.5%	20.0%	2.52%	55.6%
ACB + Valve		13	2	12.2%	15.4%	1.92%	45.4%
Non CE and Non-Kaiser MDs	224	12			5.4%	2.80%	9.2%
ACB only Other MDs	131	6		3.7%	4.6%	0.17%	9.7%
Isolated Valve Other MDs	31	2		4.8%	6.5%	0.79%	21.4%
ACB + Valve Other MDs	11	2		6.9%	18.2%	2.28%	51.8%
Summit total	342	22			6.4%	4.08%	9.6%
2004							
	2004	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE		97	9		9.3%	4.30%	16.9%
ACB only		58	4	3.8%	6.9%	1.91%	16.7%
Isolated Valve		15	2	5.0%	13.3%	1.66%	40.5%
ACB + Valve		5	0	12.2%	0.0%	0.00%	45.1%
Non CE and Non-Kaiser MDs	244	10			4.1%	2.00%	7.4%
ACB only Other MDs	127	2		3.1%	1.6%	0.19%	5.6%
Isolated Valve Other MDs	38		*	*	0.0%	0.00%	7.6%
ACB + Valve Other MDs	18		*	*	5.6%	0.14%	27.3%
Summit total	341	19			5.6%	3.40%	8.6%
2005							
	2005	n	Deaths	Predicted Mortality	Mortality	95% CI Low	95% CI High
CE		21	1		4.8%	0.12%	23.8%
ACB only		15	1	6.9%	6.7%	0.17%	32.0%
Isolated Valve		2	0	2.4%	0.0%	0.00%	77.6%
ACB + Valve		1	0	1.1%	0.0%	0.00%	95.0%
Non CE and Non-Kaiser MDs	75	2			2.7%	0.32%	9.3%
ACB only Other MDs	38	1		3.2%	2.6%	0.07%	13.8%
Isolated Valve Other MDs	7	0		5.2%	0.0%	0.00%	34.8%
ACB + Valve Other MDs	3	0		6.1%	0.0%	0.00%	63.2%
Summit total	96	3			3.1%	0.65%	8.9%

CONFIDENTIAL

	1999 through April 2005 total					
	n**	Deaths	Predicted Mortality	Mortality	85% CI Low	95% CI High
CE	431	32		7.4%	5.13%	10.3%
ACB only	295	13	3.3%	4.4%	2.40%	7.4%
Isolated Valve	45	5	3.8%	11.1%	3.71%	24.1%
ACB + Valve	24	4	10.7%	16.7%	4.75%	37.4%
Non CE and Non-Kaiser MDs	1591	59		3.8%	2.90%	4.8%
ACB only Other MDs	1008	31	3.6%*	3.1%	2.21%	4.3%
Isolated Valve Other MDs	207	3	5.4%*	1.5%	0.30%	4.2%
ACB + Valve Other MDs	103	6	8.0%*	5.8%	2.17%	12.3%
Summit total	2022	91		4.5%	3.64%	5.5%

* Weighted average of relevant predictions weighted by number of patients to which predictions applied

CONFIDENTIAL

1 **I. THE CCORP DATA IS THE BEST AVAILABLE**

2 The State of California compiles statistics relating to every hospital where cardiac
 3 surgeries are performed and every cardiac surgeon who performs them. After rigorous statistical
 4 analysis, the State publishes this data.¹ Dr. William Weintraub, a nationally recognized
 5 epidemiologist and Cardiology Section Chief at Christiana Care Health System in Newark, had
 6 this to say about the CCORP data:

7 I also reviewed the statistical approach used by the State of California
 8 in its report concerning mortality rates in 2003 and 2004 for cardiac surgeons
 9 statewide performing isolated coronary bypass surgeries, also known as the
 10 CCORP report. The approach taken in the CCORP report is consistent with
 11 the best mathematical methods for risk adjustment, using the multivariable
 12 approach logistic regression to correct for confounding. In this report Dr.
 13 Ennix is not listed as a surgeon with worse performance than peers. His risk
 14 adjusted mortality for coronary bypass surgery straddles the state average,
 15 meaning that there is no evidence that Dr. Ennix's performance, based on
 16 mortality is worse than the state average of his peers. *This report should be
 17 considered the definitive assessment of surgical mortality for isolated
 18 coronary bypass surgery by surgeon for the State of California.* There are two
 19 reasons for this, first related to the large sample size of the control number of
 20 surgeons and surgeries (that is all other providers), and the second is that the
 21 State of California report is created independently of any one health care
 22 system.

23 See Weintraub Declaration, ¶ 5, filed on March 27, 2008 (emphasis added).

24 Defendant does not dispute Dr. Weintraub's opinion about the reliability and
 25 trustworthiness of CCORP's data. Instead, it argues that the data is irrelevant.

26 **II. THE CCORP DATA IS DIRECTLY RELEVANT.**

27 The CCORP data deals with precisely the timeframe at issue in this case: 2003-2004.
 28 Dr. Ennix was subjected to peer review in early 2004 after he performed his first four minimally
 29 invasive surgeries in January and February of 2004. When he was then subjected to further
 30 review, that review encompassed six other cases, all but one of which occurred in 2003 (the
 31

32 ¹ The report is quite lengthy. It was attached as Exhibit Z to the Declaration of Andrew
 33 E. Sweet in opposition to summary judgment filed on March 27, 2008. It is also available on
 34 line at http://www.oshpd.cahw.net/HID/Products/Clinical_Data/CABG/03-04fullreport.pdf.

1 remaining case occurred in 2002). Defendant disingenuously argues that the CCORP data is
 2 “truncated” because it covers only 2003 and 2004, while the inaccurate data on which Defendant
 3 purportedly relied went back to 1999. But Defendant cites no evidence that Dr. Ennix’s
 4 mortality rates from 1999 to 2002 had any bearing on the peer review that took place in 2005
 5 regarding his performance in cases from 2003 to 2004.

6 Next, defendant claims the CCORP data is “irrelevant” because it relates only to coronary
 7 bypass (or CABG) procedures. Defendant suggests that its Ad Hoc Committee was concerned
 8 with Dr. Ennix’s mortality rate for other surgical procedures besides CABG procedures. There
 9 are three problems with Defendant’s argument. First, ten cases of Dr. Ennix were scrutinized.
 10 Four were not CABGs – they involved the new MIV technique. It is undisputed that Dr. Ennix
 11 agreed not to perform further MIV procedures so his mortality rate regarding those cases is
 12 irrelevant. Further, only one MIV procedure had been performed at ABSMC prior to Dr.
 13 Ennix’s four cases, so there could be no apples-to-apples comparison of mortality rates in MIV
 14 cases even if ABSMC had wanted to do one.

15 Second, the other six cases were *all CABGs*; none were valve procedures. If ABSMC
 16 was concerned about Dr. Ennix’s outcomes in cases other than CABGs, then why did it not have
 17 any of those cases peer reviewed or send any of those cases to its outside “experts”? Indeed,
 18 defendant cites no evidence in support of its disingenuous assertion that mortality rates for valve
 19 procedures was a “significant basis for the peer review of Plaintiff’s surgical practices.”

20 Third, every statistician that has looked at the data on which the AHC relied has
 21 concluded that the sample size for non-CABG procedures was so small that no reliable
 22 conclusions could be drawn from the data. See, e.g., Weintraub Decl., Ex. A, p. 6. This is true
 23 even for the statistician retained by ABSMC’s outside expert, Dr. Neil Smithline, as his
 24 deposition shows:

25 Q. Who is Christy Moynihan?
 26

27 A. She is a health services researcher, slash, statistician person we work with.
 28

1 Q. And so you've worked with her -- you had worked with her frequently prior to this
2 Ennix report?

3 A. I would not say frequently, but maybe on two or three occasions.

4 Q. And what kind of assignments had she had on those other occasions?

5 A. I don't recall. You know, where we needed statistical support or analysis.

6 Q. That's what I was getting at. She's someone you hired for statistical analysis?

7 A. Yes.

8 * * *

9 Q. And in it I'm going to tell you how I read this, and tell me if this is a fair reading.
She was telling you that she looked at two --

10 A. Starting with the March 6th one?

11 Q. Yes -- two sets of data, data that involved valve procedures, on the one hand, and the
12 other hand, she looked at data that involved combined CABGs and valves, right?

13 A. Yes.

14 Q. And she told you that for the valve cases there were too few cases to do any
15 statistical analysis, right?

16 A. Yes.

17 Smithline Deposition: 186:24-187:13; 226:21-227:8

18 Finally, even if ABSMC had been concerned with non-CABG cases, and even if it were
19 concerned about Dr. Ennix's performance in years before 2003, that would go only to the weight,
20 not the admissibility of the CCORP data.

21 **III. THE CCORP DATA SHOWS THAT DR. ENNIX IS NOT AN OUTLIER.**

22 The CCORP data shows the following:

- 23 1. In 2003 and 2004, 43 cardiac surgery patients undergoing CABG procedures at
24 ABSMC died.
- 25 2. During that period, Dr. Ennix experienced six deaths in 135 CABG procedures at
26 ABSMC, and had a risk-adjusted mortality rate of 4.79.

3. Dr. Ennix's Caucasian colleague, Leigh Iverson, experienced five deaths in 89 CABG procedures at ABSMC, and had a risk-adjusted mortality rate of 6.45.
4. Dr. Ennix's other Caucasian colleague, Russell Stanten, experienced four deaths in 109 CABG procedures at ABSMC, and had a risk-adjusted mortality rate of 3.69.

This data shows a number of things. First, the data on which the AHC purportedly relied does not correlate with the data ABSMC reported to the State, so either the data it reported to the State is false, or it chose to rely on other data that it knew (or should have known) was false.²

Second, Dr. Ennix's mortality rate is slightly higher than one Caucasian colleague and slightly lower than another Caucasian colleague. In other words, he is not an outlier.

Third, ABSMC professed concern about patient safety is belied by the fact that it investigated only the deaths involving Dr. Ennix and not the deaths associated with his Caucasian colleagues with similar mortality rates.

CONCLUSION

For the foregoing reasons, the Court should deny this motion and permit Dr. Ennix to inform the jury about what the best statistical evidence shows about Dr. Ennix's mortality rates during the relevant time frame, and how that data contrasts with the faulty data on which the AHC purportedly relied.

Respectfully submitted,

Dated: May 9, 2008

MOSCONE, EMBLIDGE & QUADRA, LLP

By:

G. Scott Emblidge

Attorneys for Plaintiff

² Defendant's relevance argument based on the fact that the AHC did not review the CCORP data misses the mark. The CCORP data comes from ABSMC (see CCORP report at p.3), so the AHC had the same data at its fingertips. Given its ability to easily access accurate data, the AHC's reliance on inaccurate data to condemn Dr. Ennix is all the more outrageous.